Social Work Programs Overview

As you complete the application process you will be asked to indentify your specific interest. As the VA offers such a broad scope of services, we have included a brief overview of potential concentration areas. ***Please note that openings in each area identified below are not guaranteed and this listing is provided as a general aid in completion of your application.***

MENTAL HEALTH PROGRAMS: INPATIENT/OUTPATIENT AND COMMUNITY BASED

DOMICILAIARY (DOM)

Domiciliary Residential Rehabilitation and Treatment Programs (DOM) provide coordinated, integrated rehabilitative and restorative clinical care in a bed-based unit. The goal is to help eligible Veterans achieve and maintain the highest level of functioning and independence possible. Veterans must be capable of daily self-care and not require any assistance in performing activities of daily living. Veterans may suffer from a wide range of problems, illnesses, or areas of dysfunction, which can be medical, psychiatric, vocational, educational, or social. The peer community provides a conscious, purposeful way to facilitate social, psychological, and behavioral change. Multiple therapeutic and rehabilitative activities are used, designed to produce therapeutic and educational changes, and all participants, Veterans and staff, are considered mediators of these changes. Social workers are an integral member of the interdisciplinary clinical teams who develop, integrate, and coordinate comprehensive and individualized treatment plans. The social worker may also perform outreach duties, and provide post-discharge follow-up, screenings, and referral community resources.

HEALTH CARE FOR HOMELESS VETERANS (HCHV) Programs

Health Care for Homeless Veterans (HCHV) is a community-based, mental health program which provides a broad array of services for Veterans who are homeless or at-risk for homelessness. The Homeless Program consists of a multidisciplinary team which provides services which range from Prevention (Justice-Programs) to Outreach to Permanent Housing solutions. Many social workers in designated programs offer some or all of the following services: outreach, walk-in/triage, social work assessment and referral, case management and treatment planning, psychiatric evaluation, VHA benefits assistance, support and education groups, and assistance with access to support services such as showers, laundry, lockers, mail, and transportation. HCHV includes the following programs:

- **GRANT & PER DIEM**

The VHA's Homeless Providers Grant and Per Diem Program (GPD) is offered annually (as funding permits) to fund community agencies providing services to homeless Veterans. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling) are eligible for these funds. The social workers in GPD are most often program coordinators or liaisons, serving a vital link between the community service provider and the VHA, and providing oversight for clinical services and fiscal arrangements. The social workers may provide case management, advocacy, resource and referral linkages, crisis counseling, and consultation. They often coordinate the yearly inspections and are responsible for communicating needs and challenges to VHA leadership.

Social Work Programs Overview

- **HEATLH CARE FOR RE ENTRY VETERANS (HCRV)**

Health Care for Re-Entry Veterans' (HCRV) goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community re-adjustment, and decrease the likelihood of re-incarceration for those leaving prison. HCRV services by a social worker include outreach and pre-release assessments services, referrals and linkages to medical, psychiatric, and social services, including employment services, and short term case management assistance. A critical part of HCRV is providing information to Veterans while they are incarcerated so they may plan for their own community re-entry and maintain the highest level of independence possible.

- **HOUSING AND URBAN DEVELOPMENT –VETERANS ADMINTRATION SUPPORTIVE HOUSING PROGRAM (HUD-VASH)**

HUD-VASH is a collaborative effort, supported through HUD Section 8 "Housing Choice" rental assistance vouchers and VHA's provision of intensive case management services. The HUD-VASH program is designed to support the national goal of ending chronic homelessness for the hardest-to-serve individuals who are often living with a disability, mental illness, or addiction. The primary components of the program are rental assistance (Section 8 vouchers) managed by the local Public Housing Authorities and VHA case management services designed to improve the Veteran's physical and mental health, and enhance his/her ability to remain stable, housed, and community-integrated.

Veteran participants in the HUD-VASH Program must be eligible for VHA health care, must be homeless, and must have an identified need for case management services. Veterans with acute medical, substance use disorders, and/or mental health needs may be admitted to the program for case management; however, these needs must be met prior to placement in Section 8 housing.

- **VETERANS JUSTICE OUTREACH (VJO)**

The Veterans Justice Outreach (VJO) initiative is designed to provide outreach to Veterans in contact with the justice system through encounters with police, jails, and courts. The goal of the VJO program is to provide timely access to VHA services for eligible justice-involved Veterans to avoid unnecessary criminalization and incarceration of Veteran offenders with mental illness. VJO services provided by a social worker involve direct outreach, assessment, and case management for justice-involved Veterans in local courts and jails, and act as a liaison with local justice system partners. The VJO Specialist (SW) also acts as a liaison with the local Veterans Treatment Courts (problem solving courts) within the VA's catchment area. The difference between VJO and HCRV program is that the HCRV targets Veterans who are already incarcerated and are planning re-entry back to community. The VJO program makes contact prior to incarceration as prevention.

MENTAL HEALTH -OUTPATIENT

Inpatient psychiatric units provide a psychiatric milieu for Veterans with acute mental health needs; specific programmatic offerings vary between medical centers. Social workers play an integral role in the overall coordination of aftercare and discharge planning, and are a valued member of the interdisciplinary clinical team. Social workers perform initial comprehensive assessments and may be responsible for facilitating family meetings and other communication with outside agencies. Social Workers facilitate inpatient psycho-educational groups on inpatient units that relate to improved coping skills, interpersonal

skills, and stress reduction. Social workers ensure that Veterans have follow- up appointments with mental health and medical providers if needed. They may also assist in housing, food, and benefit needs. In addition, social workers may perform post-discharge calls to evaluate the transition from inpatient to home or another natural environment.

MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

MHICM has two distinct branches, Intensive Psychiatric Community Care (IPCC) and Satellite Day Treatment Centers (SDTC), with the overall mission to optimize the health, quality of life, and community functioning of Veterans with serious mental illnesses who are high users of VHA mental health inpatients services.

The social workers role is to plan, develop, and conduct a program of casework and group work services, integrated with a biopsychosocial program, which contributes to the overall aims of the medical center. The social worker provides services to patients and their families who are experiencing emotional, social, or economic problems of a serious or complex nature. These services are primarily provided in the community, often within the Veteran's own home. The social worker is a valuable member of an interdisciplinary team and participates is activities designed to gain a total understanding of the patient's needs and problems, such as daily briefings, treatment planning conferences,. Seriously Mentally Ill (SMI) Veterans are seen for management of mental health care due to decompensation of their mental status, psychosis, suicidal ideation, homicidal ideation, noncompliance with medication/treatment plan, and medication side effects.

MILTARY SEXUAL TRAUMA (MST)

Every VHA hospital/medical center has a designated Military Sexual Trauma (MST) Coordinator who serves as a contact person for MST-related issues. The MST Coordinator serves as an advocate and can help find and access VA services and programs, state and federal benefits, and community resources for victims of MST. The VHA provides free, confidential counseling and treatment for mental and physical health conditions related to experiences of MST.

OPERATION ENDURING FREEDON/OPERATION IRAQI FREEDOM CARE MANAGEMENT (OEF/OIF)

Every VA Medical Center has an OEF/OIF Care Management Team ready to welcome recently returning Veterans and Active Duty Servicemen to help coordinate their care. Each team consists of a Program Manager and Clinical Case Manager(s). Social workers serve as program managers or case managers to organize patient care activities and help Veterans navigate their way through the VA system. Case managers work closely with Military Treatment Facilities (MTF) and the Department of Defense (DOD) to ensure that Veterans make a seamless transition from active duty to Veteran status.

The OEF/OIF Care Management Team is responsible for documenting and tracking Veterans receiving case management services in the national Care Management Tracking and Reporting Application (CMTRA). The members of the Care Management Team attend National Guard and Reserve outreach events, such as Pre-mobilizations, Demobilizations, Yellow Ribbon Reintegration's (YRRP), and Post-Deployment Health Re-Assessments (PDHRA), to enroll and educate the Veterans on their health care

benefits and VHA services. Additionally, the OEF/OIF Care Management Team holds an annual Welcome Home Event for all the OEF/OIF Veterans and their families.

POLYTRAUMA

VHA offers specialized expertise in the care of patients with multiple traumas at VHA Polytrauma Rehabilitation Centers (PRC) located at the. PRCs provide coordinated health and rehabilitation services to active duty service members and Veterans who have experienced severe injuries resulting in multiple traumas, including spinal cord injuries, traumatic brain injuries (TBI), visual impairment, amputations, combat stress, and Post-traumatic Stress Disorder (PTSD). Twenty-one Polytrauma Network Sites were designated in 2006 to provide continuity of care in the outpatient setting in Veterans' home areas to enhance therapy and service needs of the patients. These are interdisciplinary outpatient teams comprised of nurses, social workers, psychologists, and rehabilitation therapy staff.

Polytrauma clinical case management and care coordination is provided to polytrauma patients across the continuum amongst various systems of care. This involves acting as the primary case manager for emerging medical, psychosocial, or rehabilitation problems, managing the continuum of care, care coordination, acting as patient and family advocate, and assessing clinical outcomes and satisfaction.

POST TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) program social workers in the VHA specialize in PTSD and provide many types of therapeutic services to Veterans who have, or are suspected to have, PTSD. These services include initial and diagnostic assessments; referrals to services and information about resources; education to Veterans and families; therapy and psychoeducational groups, including Cognitive Processing Therapy (CPT) groups; and individual intensive therapy.

PSYCHOSOCIAL RECOVERY AND REHABILATION CENTER (PRRC)

The Psychosocial Rehabilitation and Recovery Center (PRRC) goal is to help Veterans with chronic severe mental illness, such as Schizophrenia, Major Depression, Bipolar Disorder, and PTSD, lead more fulfilling lives and develop their full potential. Veterans participate in classes aimed at promoting community integration through effective symptom management, communication, and coping, as well as expressive arts skills. Multidisciplinary staff, including social workers who serve as program managers, counselors, and teachers, support Veterans to address a variety of issues, such as stigma and recovery, and utilize peer support as a foundation.

SUBSTANCE ABUSE/ADDICTIONS TREATMENT PROGRAM

Substance abuse programs across VHA Medical Centers vary widely and range from supportive psychotherapy drop-in groups to residential programs. VHA Medical Centers also may have opioid treatment programs where methadone and suboxone is available. Social workers perform comprehensive assessments, provide various types of evidence-based therapies, and coordinate the Veterans' medical and psychiatric needs. In addition, they facilitate support groups and perform alcohol breathalyzer tests to ensure that Veterans' needs are addressed.

Substance abuse treatment groups that may be offered:

- Intensive Outpatient Program or Day program: Time limited intensive structured program ranging from four days to two weeks

Social Work Programs Overview

- Drug and Alcohol Treatment Program: Combination of assessment, group treatment, and/or individual treatment following a prescribed Phase program or similar, implementing individualized treatment plans for Veterans
- Specialty Treatment Programs: These specialty programs provide specific interventions for particular populations or needs such as Substance Use, PTSD and Dual Diagnosis
- Upload Treatment or Opioid Replacement Program: Comprehensive program where Veterans are dispensed either Methadone or Suboxone, then are placed on a comprehensive protocol and monitored by a multi-disciplinary team
- Types of Groups: Sobriety Support Drop-In , After –Care, Anger Management, Gambling, Process, Mood Management, Relapse Prevention, Resentment, Recovery, SATP Orientation , Self Reflection and Women's

SUICIDE PREVENTION

VHA mental health officials estimate there are 1,000 suicides per year among Veterans receiving care within VHA and as many as 5,000 per year among all living Veterans. In response, the VHA has created a National Suicide Prevention Plan. The Suicide Prevention Coordinator (SPC) manages the national suicide prevention plan at the facility level. SPCs have multiple responsibilities to Veterans and their families, VHA staff, community members, and the national database. SPC responsibilities include assessing the risk of suicide in individual Veterans in conjunction with treating clinicians, and ensuring patients identified as being at high risk for suicide receive follow-up and that follow-up is documented in the electronic medical record. They work with clinicians who refer potential high risk patients for flagging to determine the advisability of the flag, review the provider-completed Suicide Behavior Reports, maintain communications with the facility-designated advisory group or committee, maintain a list of Veterans who are currently flagged and establish a system of reviewing the flags at least every 90 days, documents the nature of the follow-up and plans for continuing treatment, and identifies training needs relating to the prevention and management of suicide.

In July of 2007, the VA opened a National Suicide Hotline staffed with mental health professionals, including SPCs 1-800-273-TALK (8255). The Hotline is available 24 hours a day 7 days a week.

HEALTH CARE PROGRAMS: INPATIENT/OUTPATIENT & COMMUNITY BASED

ADULT DAY HEALTHCARE AND CONTRACT NURSING HOMES(ADHC and CADHC)

Adult Day Health Care (ADHC) programs enable elderly and disabled Veterans to reside in supportive home environments rather than in nursing homes, and improve the Veteran's quality of life by supporting their caregivers and maintaining the Veteran's highest level of functioning possible. Some VHA Medical Centers (VAMCs) have ADHC programs on site; others provide this service through contracts with local private centers (Contract ADHC). ADHC centers, on site or contracted, are therapeutically oriented ambulatory day programs that provide health maintenance and supervision to patients with a need for personal assistance with activities of daily living, medication management, or with significant cognitive impairments. ADHC services provided at a VAMC involve an interdisciplinary team of staff, which includes a social worker. The CADHC social worker provides direct services and advocacy to Veterans

and their families and provides oversight of the care provided at CADHC facilities by means of annual inspections, medical record reviews, and regular visits with the Veteran at the CADHC center every 30 days, or with a VHA nurse.

BLIND REHABILATION and LOW VISION

The VHA provides extensive blind rehabilitation and support services to visually impaired Veterans. This includes Visual Impairment Service Team (VIST) Coordinators, Blind Rehabilitation Outpatient Specialists (BROS), Low Vision Clinics, case management, and Blind Rehabilitation Centers. There are currently 10 inpatient Blind Rehabilitation Centers, with three more expected in the near future. These centers provide intensive rehabilitation services including optometry, medical support, low vision specialists, orientation and mobility, manual skills, and living skills. Instructors and blind rehab teams focus on individualized goals and incorporate the Veteran's support network into the learning process. Blind Rehabilitation Centers also utilize low vision devices and technology to support the Veteran's independence. A key component of one's blind rehabilitation may include adjustment to loss, coping skills, stress management, and community support and resources. The Blind Rehabilitation Center social worker is a key member of the interdisciplinary team. They conduct psychosocial assessments, coordinate both inpatient and outpatient services, make referrals as necessary, facilitate various psycho-educational groups, contribute to quality management operations, educate the Veteran's support network, provide outreach to stakeholders and other health professionals, communicate with the Veteran's local blind rehabilitation support services, and work with master's level graduate interns.

CAREGIVER SUPPORT

The role of the caregiver support program is to assess the strain and burden on the caregiver, explore various programs available to provide help and support to the caregiver, and describe educational and training resources that are available to the caregiver. The caregiver support program provides assistance to those who are the primary caregivers for Veterans with severe medical illness such as dementia, Alzheimer's, Spinal Cord Injury, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (also known as Lou Gehrig's disease), and HIV/AIDS.

Social workers provide not only individual and group counseling in mental health care, but also provide resource support and advocacy to Veterans with many other illnesses and their caregivers. Some of the most common support provided by VHA social workers include helping with finances or housing, help accessing community resources, help applying for benefits such as Social Security or Medicare, help with Advance Directives, and providing referrals for respite care, Meals on Wheels, long-term care services, and community counseling.

COMMUNITY BASED OUTPATIENT CLINIC (CBOC)

Community Based Outpatient Clinic (CBOC) social workers play a critical role in the Veteran's health care and must be knowledgeable about the varied aspects of the Veteran's needs, as well as appropriate services and resources within VHA and their local community. The CBOC social worker provides case management, psychosocial assessment, high-risk screening, individual, family, and group therapy, crisis intervention, advocacy, family education, service coordination, and referrals for home health services, skilled nursing care, respite care, and vocational rehabilitation. They also provide services to assist with marital, family, and legal problems, as well as employment, financial, and housing problems. CBOC

social workers also address issues such as abuse and neglect, Advance Directives, end of life planning, discharge assessment and planning, linkage with family members, linkage with and referrals to VHA and community resources, and supportive guidance. Social workers in this setting often teach patient education classes on a variety of subjects, and complete HIV Consults and consultation for HIV counseling/education.

COMMUNITY LIVING CENTER (CLC)

Each VHA Community Living Center (CLC) provides compassionate, person-centered care in a safe and home-like environment to eligible Veterans who require assistance with daily care needs. The goals of care are to restore function, reduce decline, maximize independence, and provide comfort when dying. Veterans can achieve their goals in an environment where they are respected, treated with dignity, and invited to be an active participant in their care. The CLC team emphasizes enhancing and supporting the Veteran's quality of life. CLC programs vary from one VAMC to another but can include skilled nursing, restorative care, rehabilitation, maintenance for those awaiting alternative placement, psychiatric care, dementia care, Geriatric Evaluation and Management, Spinal Cord Injury, hospice/palliative care, and respite care.

The role of the CLC unit social worker is largely dependent upon the programs offered at the particular CLC, but includes psychosocial assessments, case management, discharge planning, advance directives, and attending monthly Resident Council Meetings. Additionally, the social worker is responsible for portions of the Minimum Data Sheet (MDS) assessments and patient centered care plans. Since Veterans on the CLC are usually there for an extended period, the social worker often works very closely with the Veteran and their families to assist with coping related to aging and end of life care. Social workers are an integral member of the multidisciplinary team meetings and family meetings.

COMMUNITY NURSING HOME – CONTRACT (CNH)

The VHA Contract Community Nursing Home (CNH) Program is designed to assist eligible Veterans and their families in making the transition from an episode of hospital or domiciliary care to the community, or to provide indefinite nursing home placement for Veterans who require 24-hour medical care and/or supervision. The primary goals of the CNH Program are to meet the Veteran's health care needs, provide rehabilitation services with a goal of returning home, and promote the maximum well being of the Veteran. A Veteran is placed in a CNH when his/her medical, physical or mental condition is so impaired that he/she are unable to care for himself/herself and he/she requires 24-hour care. CNH oversight is provided by an interdisciplinary team, which includes a social worker. The CNH social worker provides direct care and advocacy to Veterans and their families, administrative oversight of the CNH facility, conducts annual reviews of contracted facilities with a team of VHA providers (including a dietician, safety specialist, nurse, social worker), reviews medical records, and visits with the Veteran at the CNH every 30 days (or with the VHA nurse). The CNH social worker also serves as a liaison between the contracted CNHs and the local VAMC. CNH programs vary widely between VAMCs, with some providing short-term contracts and others that use CNHs only for long-term care.

COMMUNITY RESIDENTIAL CARE PROGRAM (CRC)

Social Work Programs Overview

The Community Residential Care (CRC) Program, available at some medical centers, provides health care supervision using community-based residential settings for eligible, self-pay Veterans who are not in need of hospital or nursing home care, but are unable to live independently. Additionally, eligibility requirements require that the Veteran has no suitable family or significant others to provide the necessary supervision and supportive care. All homes and facilities in the CRC Program are licensed and VHA approved. Veterans are responsible for the cost of care, which includes room and board, medication supervision, 24-hour supervision, and limited assistance with activities of daily living (ADL). Veterans enrolled in this program receive at least alternating monthly visits from a VHA nurse and social worker. The program coordinator, often a social worker, acts as a liaison between the VHA and facilities and meets with the patients, families , fiduciaries, and others at the homes as necessary regarding the needs and concerns of the patients and the organization. The social worker participates in annual home and facility inspections and notifies the program director when a Community Residential Care facility does not meet the standards required by VHA. The team's goal is to provide a wide range of health services to patients, such as biopsychosocial assessments, linkage to community resources, crisis intervention, financial counseling, supportive counseling, and psychotherapy, and to coordinate discharge and transitional planning. Social workers also monitor potential cases of abuse and neglect to try to ensure Veteran safety.

DIALYSIS

The mission of the Hemodialysis Unit (HDU) is to provide dialysis and skilled nursing care to Veterans with renal failure. The HDU uses a multidisciplinary approach to meet the complex needs of Veterans with renal failure and provides a wide range of services including chronic and acute hemodialysis, continuous renal replacement therapy, peritoneal dialysis, contract dialysis, and patient education. Dialysis social workers work with Veterans and their families as part of a multidisciplinary team providing support and counseling, information about and assistance with advance directives, referrals to community resources, and community nursing home placement.

EMERGENCY DEPARTMENT (ED)

The level of care provided at the Veterans Health Administration (VHA) Emergency Department (ED) varies between medical centers. There are always multiple complex medical and psychiatric emergent situations on a given day. The hours of service also vary and many social workers provide extended care in the evenings and weekends. Some sites have a separate psychiatric emergency department, which is often staffed by social workers and other disciplines. Social workers are often the front line of contact for the Veteran in the emergency department to assist with resources, referrals, and discharge planning on many levels. Resources may include shelters and transitional housing, referrals for substance detoxification, family, or pet care for admissions, food, transportation, linkage to primary care, and supportive counseling.

GERIATRIC, RESEARCH, EDUCATION, CLINICAL CENTER (GRECC)

Geriatric Research, Education, and Clinical Centers (GRECCs) offer outpatient medical care to elderly Veterans. An interdisciplinary team works together to improve the various aspects in the quality of life and care for the older Veteran, utilizing the most up-to-date and leading edge research and education in the area of Geriatrics. GRECC staff conducts research in the area of aging with the goal to promote education, training, and clinical care for the elderly Veteran. Such research results have influenced

different medical and psychological therapies for diseases affecting older Veterans and their families/caregivers. A major component of GRECC is to disseminate information and teach interdisciplinary staff, Veterans, family members and community members about the clinical advancements in geriatrics to improve their daily lives. Social workers in a GRECC conduct psychosocial screenings and assessments that address a Veteran's physical limitations, psychological needs and age associated illnesses and conditions. In collaboration with the interdisciplinary team, Veteran, and family/caregiver, the social worker develops goals and treatment plans designed to promote health, daily functioning and adjustments to the aging process. Social workers make referrals to Veterans Health Administration (VHA) and community agencies, collaborate with service providers, provide supportive counseling through individual, couple, and family therapy, provide crisis intervention, and advocate within VHA and/or community agencies. Social workers also provide education to promote health, wellness, and advanced planning for the elderly Veteran. There are 20 GRECCs throughout the VHA system.

HOME BASED PRIMARY CARE (HBPC)

Home Based Primary Care (HBPC) is a VHA program that delivers primary health care in the home using a hospital based interdisciplinary team to homebound, and often bedridden, eligible Veterans. This program provides Veterans with individual medical, nursing, social, dietetic, pharmacy, and rehabilitation services within the milieu of the Veteran's home and family. HBPC is a direct care outpatient program providing health care to individuals who require continuing care and for whom follow-up in an outpatient clinic is not feasible. The HBPC social worker provides Veterans in HBPC with high quality case management, clinical treatment, advocacy, and coordinates linkages with appropriate VHA and community service providers/agencies as needed by the Veteran. This is facilitated by maintaining home visits, and is accomplished in collaboration with other members of the HBPC Team, or other interdisciplinary treatment teams as appropriate, i.e. specialty clinics, primary care, mental health.

MEDICAL FOSTER HOME

Medical Foster Homes (MFH) provide an alternative to institutionalization, and are intended to improve the Veteran's quality of life and to provide health care in a home setting. The VHA defines a Medical Foster Home as an adult foster home that is combined with a VHA interdisciplinary home care team, such as Home Based Primary Care, to provide non-institutional long-term care for Veterans who are unable to live independently and prefer a family setting. The program coordinator is typically a social worker. Medical Foster Homes include homes are either rented or owned by a live-in caregiver who provides 24-hour supervision and needed personal care for no more than three residents, including Veterans and non-Veterans, and the Veteran(s) in the home is enrolled in the Home Based Primary Care Program.

The MFH target population includes eligible Veterans who meet nursing home level of care, are unable to live independently due to functional, cognitive, or psychosocial impairment, prefer a non-institutional setting for long-term care, and have the financial resources, or eligibility for VHA benefits, to pay for care on an ongoing basis. Duties of the program coordinator include: (1) Maintaining appropriate working relationships with all levels of VHA staff including the Veteran's VHA care manager and interdisciplinary home care team; (2) Recruiting, and recommending approval of new homes that could provide care to Veterans in need of MFH care; (3) Assessing potential MFH environments for needed structural alterations; facilitating Home Improvement Structural Alterations (HISA) grant, if needed; (4) Ensuring initial and annual home inspections are done by the interdisciplinary VHA inspection team; and (5) Ensuring a safe, suitable, and therapeutic environment for Veterans residing in MFH.

Social Work Programs Overview

MEDICAL-INPATIENT

Medical-inpatient usually admits Veterans who are not assigned to a specialty care team (surgery, cardiology, neurology, etc.). Often these patients have chronic diseases, such as end stage renal diseases, diabetes, COPD, CHF and vascular disease, and/or an acute illness, such as gastrointestinal (nausea, vomiting, diarrhea) or pneumonia. A Veteran could also be admitted for alcohol abuse/intoxication and need to be medically stable before admittance to a treatment program.

A medical-inpatient social worker usually completes a psychosocial assessment to determine discharge and coping needs. Discharge needs could include acute rehab placement, skilled nursing placement and/or in-home care (homemaker chore, home based primary care, home health). Social workers often are in charge of coordinating the discharge to make sure that all discharge services are in place and discharge transportation has been arranged. Social workers also provide support to Veterans and/or families for coping related to diagnosis and may lead family meetings. Veterans are usually seen on an inpatient basis while they are admitted to the hospital.

NEUROLOGY

Neurology is a field of medical practice that deals with disorders of the nervous systems. Specifically, it deals with the diagnosis and treatment of all categories of disease involving the central (brain and spinal cord), peripheral, and autonomic nervous systems. The corresponding surgical specialty is neurosurgery. Neurological episodes include, but are not limited to, migraine headaches, strokes, traumatic brain injury, spinal cord trauma, cerebral palsy, epilepsy, Alzheimer's disease, and Parkinson's disease.

A neurology and/or neurosurgery social worker usually completes a psychosocial assessment to determine discharge and coping needs. Discharge needs could include acute rehabilitation placement, skilled nursing placement, and/or in-home care (homemaker chore, home based primary care, home health). Social workers are often in charge of coordinating the discharge to make sure that all needed durable medical equipment has been provided, discharge services are in place, and discharge transportation has been arranged. Social workers also provide support to Veterans and/or families for coping related to diagnosis and possible lifestyle changes after a neurological episode and/or neurosurgery. Veterans are usually seen on an inpatient basis either before/after surgery or in the clinic during follow-up appointments.

ONCOLOGY

Oncology is the area of medicine that deals with the study and treatment of cancer. Clinical social work services provided in the inpatient oncology unit and outpatient clinics include assisting with Veteran/family care issues, patient education, supportive counseling, case management, and discharge planning. Social workers ensure efficient and professional services for oncology patients and their families designed to promote and enhance their physical and psychosocial functioning, with attention to the social and emotional impact of the illness and disability. As a member of a multi-disciplinary team, the social worker is responsible for assessing and providing support and intervention for the social and emotional needs of Veterans and their families to promote continuity of care.

PALLATIVE CARE/HOSPICE PROGRAM

Social Work Programs Overview

The Palliative/ Hospice Care Program provide holistic care to Veterans threatened with a life-limiting illness. Focus is often on symptom management and comfort for the Veteran. Along with managing physical symptoms, the team approach also helps to manage psychosocial issues and spiritual comfort to the Veteran and their support system (family, friends, primary caregiver, etc) in relation to end-of-life care. The program can serve Veterans in outpatient and inpatient settings depending on the facility. Social workers roles vary, however often they complete psychosocial assessments, coordinate referrals, provide bereavement support/education, and help with the overall communication process.

PRIAMRY CARE

Primary care social workers work in the medical clinic areas where their primary medical doctors see Veterans; these clinics are referred to by a variety of names, such as Medical Practice. Primary care social workers provide case management that includes providing information about financial resources and options, referring to collateral agencies, and ensuring coordination of services and continuity of care. Social workers provide complex and varied services including education to assist in understanding the information given by the primary care teams, information about resources in the VHA system and the community, supportive counseling for related medical issues and long-term illnesses and to problem-solve resources, identifying Veteran strengths and support systems available within the family and community, advocating for Veterans needs, explaining VHA benefits and services, providing education and assistance in completing advanced directives, and reporting suspected cases of abuse and/or neglect.

SPINAL CORD INJURY (SCI)

Spinal Cord Injury programs (SCI) have both inpatient rehabilitation centers and outpatient clinics in the VHA to promote the physical, medical, psychological, educational/vocational and social functioning of Veterans with spinal cord injuries/disorder(s). Social workers in the SCI program assist with advance directives information, education, and referrals for VHA and/or community resources. Social workers also provide supportive counseling to Veterans and their families, advocacy, crisis intervention, case management, and coordination of discharge planning. They work with multidisciplinary teams that often include physician(s), nursing, occupational therapy, physical therapy, and pharmacy.

There are 24 inpatient spinal cord injury centers located throughout the United States that provide intensive rehabilitation therapy to SCI Veterans. Several SCI clinics assist with follow-up care and in-home needs once the Veteran discharge from inpatient rehabilitation. In order to qualify for the SCI rehabilitation center and/or SCI clinic, a Veteran needs to have a diagnosis of spinal stenosis, spinal cord injury, or multiple sclerosis; the diagnosis originates from their attending physician and then is confirmed by a Physical, Medicine & Rehabilitation (PM&R) physician.

SURGERY

Surgery social workers assist Veterans who are discharging and transitioning from the hospital back to their communities. She/he completes a psychosocial assessment to determine discharge needs, which may include assessment, resources, and referrals for transportation, community resources such as Lifeline and Meals on Wheels, and arranging for in-home services, such as home care services, and/or nursing home placement for short-term skilled rehab. Often, surgery patients need arrangements made for home intravenous (IV) antibiotics and/or home wound care. Social workers also provide support to Veterans and/or families for coping related to diagnosis and possible lifestyle changes after surgery. Veterans are

usually seen on an inpatient basis either before and/or after surgery and may be seen by social workers in the clinic during follow-up appointments.

TRANSPLANT

The Transplant social worker assists Veterans and their families with non-medical issues that may arise before, during, or after organ or tissue transplantation. The social worker completes a comprehensive evaluation on potential recipients and donors. He/she assists Veterans and their families manage the complex emotional, personal, social, and psychological issues of transplantation throughout the transplant process.

TRAUMATIC BRAIN INJURY (TBI)

Each VHA Medical Center has a TBI Coordinator, who assists Veterans diagnosed with mild and moderate to severe traumatic brain injury. Services include assisting with appointments and managing the Veterans overall care. The TBI Coordinator refers Veterans to community and VA resources and can facilitate locating resources for Veterans with financial problems, transportation issues, housing/homelessness, and VBA benefits and claims. The TBI Coordinator tracks Veterans listed in the National TBI Registry Database and is responsible for data collection and action plans related to TBI Performance Measures.

VISION IMPAIRED SERVICE TEAM

The Vision Impaired Service Team (VIST) Coordinator is responsible for overseeing and coordinating vision rehabilitation services for eligible Veterans and is the VHA Medical Center's primary contact(s) for matters related to blind or vision impaired rehabilitation. This includes assessing referred Veterans for VIST eligibility, tracking VIST eligible Veterans in the VHA Blind Rehabilitation Services (BRS) database, completing annual reviews with each VIST Veteran to determine further plan of care, and educating Veterans about VHA and non-VHA benefits and community resources for Veterans with blindness or vision impairment. The VIST Coordinator handles all of the referrals to VHA Blind Rehabilitation Centers, where Veterans can receive the most comprehensive level of blind rehabilitation services and training. The VIST Coordinator may lead a support group and serves as the public relations contact and intra-service contact for matters related to vision rehabilitation. He/she is responsible for providing in-service trainings to VHA and non-VHA staff throughout the year. There is some variance nationwide regarding the type of blind or vision impaired rehabilitation services that can be provided locally.

WOMEN VETERANS PROGRAM

The Women Veterans Program offers services designed to meet the needs of women Veterans Services including primary care, pap smears, breast screening, mammography, birth control, menopause treatment, sexual trauma counseling, and fee basis maternity care. Eligible Veterans may be provided with substance abuse treatment, surgical, mental health, HIV counseling, referrals that range in complexity from HIV Counseling to a referral for Military Sexual Trauma. Social workers may serve as the Women Veterans Program Manager (WVPM), which combines clinical and administrative program management. The WVPM is responsible for outreach to women Veterans, education within the VHA,

coordinating services, improving services, coordinating designated performance measures, and the overall functioning of the women Veterans' health program.

VHA SOCIAL WORK MANAGEMENT AND ADMINSTRATION

SOCIAL WORK ADMINISTRATION

Social workers are responsible for leadership at all levels of the organization. At VHA Social Work and Case Management Service, the VHA Central Office (VACO) staff provides oversight and direction to all social workers in the VHA. On a local VAMC level, a designated Social Work Executive is responsible for aspects of the social work profession, (see VHA Directive). The Social Work Executive may often be the Chief or Assistant Chief of a designated Social Work Service or a Director of a Care Line Service or a social worker in a Care line or program, depending on the structure of the institution.

In addition, many social workers are program coordinators who coordinate and oversee a complex array of programs and responsibilities including services, budgets, and clinical and program planning. Program coordinator positions that are primarily administrative include Education and Quality Management. Social Work Supervisors provide individual supervision and/or program coordination to social workers and/or other staff in many VHA programs. Administrative Practicum may be available on a case by case basis.